STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#1) of five residents reviewed for accidents out of five sample residents.Resident #1 was admitted on [DATE] for postoperative left knee replacement rehabilitation services and physical therapy. Resident #1 was determined to be a high fall risk related to her postoperative status and history of falls. On 10/17/25 Resident #1 sustained an unwitnessed fall when she was left unattended in the bathroom.On 10/24/25 Resident #1 sustained an additional fall when she was left unattended in the shower. She sustained a left femur fracture that was deemed inoperable for repair. Specifically, the facility failed to ensure fall interventions were consistently implemented for Resident #1, which resulted in a fall with major injury. Findings include:I. Facility policy and procedureThe Fall Prevention policy, revised 7/24/23, was provided by the nursing home administrator (NHA) on 11/5/25 at 4:50 p.m. It read in pertinent part, Falls in the skilled nursing setting represent one of the most potentially devastating occurrences that can negatively impact a patient's recovery. In facility, falls directly cause tens of thousands of bone fractures, intracranial hemorrhages, re-hospitalizations and deaths every year in the United States. It is because of these unfortunate events that The (name of facility) are implementing its comprehensive program to prevent falls and injury. Any patient deemed to be high risk by nursing and/or therapy staff will have the following interventions at least considered: Thorough physical therapy and occupational therapy evaluation, routine toileting schedule throughout shift and line of sight as needed. If an unwitnessed fall occurs, risk management to be completed and determine what interventions need to be implemented to prevent further falls. II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE] and discharged to the hospital on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included fracture to the left femur with surgical intervention, difficulty walking, muscle weakness and a history of falls prior to admission. The 10/14/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. The 10/28/25 MDS assessment revealed Resident #1 required supervision or touching assistance with toileting hygiene and showers and bathing. She required supervision or touching assistance with sit to stand transfers, toileting transfers and shower transfers. B. Resident #1's representative interviewResident #1's representative was interviewed on 11/5/25 at 9:26 a.m. The representative said the evening shift staff informed her of Resident #1's fall. She said the staff only gave Resident #1 Tylenol as ordered for pain and could not exceed the resident's dose of Tylenol due to potential liver damage. She said she asked the staff if they had called the doctor and the staff did not have an answer for her. She said the staff continued to transfer the resident improperly. She said the resident had pain from her hip to her foot. She said she was told by nursing staff that the resident's left knee prosthetic fracture was displaced and was now (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	received from the NHA on 11/5/25 at 1:30 p.m. The investigation documented that on 10/24/25 Resident #1 had an unwitnessed fall in her bathroom while taking a shower after certified nurse aide (CNA) #2 left the resident alone in the shower. Resident #1 tried to get out of the shower without calling for assistance. The resident said she tried to get out of the shower and did not call for help. The resident was assessed by a registered nurse (RN). The physician checked on the resident and decided to delay the resident's discharge for a few days to monitor. Xrays of the resident's ankle and knee were ordered. The physician's orders included elevating the resident's left leg and to apply ice to the swelling. The director of nursing (DON) and the family were notified. Neurological checks were initiated. Resident #1 was assisted from the floor using a gait belt. CNA #2 was provided education on 10/24/25 regarding the importance of supervision and adherence to care plan, safe transfer and bathing techniques, reporting and documentation requirements after a fall and emotional and physical impacts of falls on a resident. The Xray results revealed a fracture to the neck of Resident #1's left femur bone. The resident was sent to the hospital for further treatment. The 10/25/25 hospital documentation indicated Resident #1 sustained a femur fracture that was inoperable due to the residents' comorbidities. It was decided the resident would transition to hospice and comfort care made by the resident and her family. The IDT facility discharge summary on 10/23/25 revealed Resident #1 had a planned discharge scheduled for 10/24/25 to go home with family supervision. The summary documented physical therapy recommended the resident should initially have supervision for all functional tasks and mobility upon discharge using an assisted device to decrease risk of falls. The resident should continue with outpatient skilled therapy services to increase strength and improve functional performance with tasks. III. Staff interviewsCNA #3 was interviewed on 11/5/25 at 11:29 a.m. CNA #3 said if a resident was a fall risk, he did not leave them alone in the shower. He said residents could fall very quickly so it was very important to stay close by any resident while providing care assistance. He said the nursing staff knew what care to provide to residents based on the electronic medical record (EMR). He said Resident #1 was a fall risk and was in a room close to the nurses' station. He said her assistive needs were also written on the white board in her room. CNA #1 was interviewed on 11/5/25 at 12:05 p.m. CNA #1 said the falling star symbol on a resident's door indicated the resident was a fall risk. CNA #1 said Resident #1 was a fall risk, as she frequently ambulated by herself. CNA #1 said the resident had tried to get up by herself six or seven times and had to be redirected. CNA #1 said the resident was difficult to redirect, as she was fixated on getting back in bed and did not want the staff to help her wipe or pull her pants up. CNA #1 said the resident was on frequent checks to help with fall prevention.Licensed practical nurse (LPN) #1 was interviewed on 11/5/25 at 12:14 p.m. LPN #1 said she was Resident #1's assigned nurse on 10/24/25 when Resident #1 fell and sustained a femur fracture. LPN #1 said Resident #1 was admitted to the facility for rehabilitation because she had fallen and had surgery. She said the resident had a wristband that indicated she was a fall risk and had fall signage in her room. She said the fall on 10/24/25 occurred at 10:20 a.m. She said she was passing medication to other residents when she was notified by another staff member that the Resident #1 was on the floor in her bathroom. LPN #1 said when she arrived to the resident's room, she noticed Resident #1 was on the floor in the shower. She said Resident #1 was covered in water and had a towel around her. LPN #1 said the resident was assessed and a physician's order was obtained for an Xray. LPN #1 said CNA #2 was assisting the resident with a shower and left the resident unsupervised to get supplies. LPN #1 said CNA #2 should not have left the resident in the shower alone because she was a fall risk and had fallen in the past while in the bathroom. LPN #1 said CNA #2 should have utilized the call light to have another staff member bring the supplies to (continued on next page)

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